MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13 la

CERTIFICATE OF DEATH

08177

Reg. Dist. No. 248

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Prince Georges
City or town: Edmonston
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 yrs.
Hospital, institution, or street address where death occurred:
4811 52nd Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pri. Geo.
City or town: Edmonston
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4811 52nd Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: HOBART McKINLEY ARMENTROUT

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Estelle Armentrout
6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): ~~Oct.~~ 11-19-1891

8. AGE: Years: 50 | Months | Days | If less than one day: hrs. min.

9. Birthplace: West Virgina
(Town, county, and state)

10. Usual occupation: Fuel Oil Salesmans

11. Industry or business: Own Business

FATHER
12. Name: Unknown
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Unknown
15. Birthplace: W. Va.

16. Informant: Mrs. Mary E. Armentrout
4811 52nd Ave., Edmonston, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 10. 1947 (month) (day) (year)
Cemetery or crematory: Blue Field
Location: West Va
18. Funeral director: L Cacchione
Address: Hyattsville Md.

19. Sept. 10th 1947 (Date rec'd by registrar) Mrs. Jas. Severe Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 9 1947, at 11 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive Heart Failure	
Due to Cardiosclerosis	
renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Respectfully Medical Extra... M. D. or Other
Address: Hyattsville Md. Date signed: 9-9-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1062

08178

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH:
County Pr Geo
City or town Laurel Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, Institution, or street address where death occurred:
Warren Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State Md County Montgomery
City or town Burtonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Ernest Edwin Arnett

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 25 - 1884

8. AGE: Years 62 | Months 11 | Days 27 | If less than one day hrs. min.

9. Birthplace Screven Co Georgia
(Town, county, and state)

10. Usual occupation Linotype operator

11. Industry or business Nash Herald Newspaper

FATHER
12. Name Hamilton Arnett
13. Birthplace Screven Co. Georgia

MOTHER
14. Maiden name Georgia Ann Dixon
15. Birthplace Screven Co. Georgia

16. Informant Hamilton Julian Arnett
Address 2440 - 16th St. N. W. Wash DC

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 23 - 1947 (month) (day) (year)
Cemetery or crematory Fort Lincoln Cemetary
Location Bladensburg Rd. Wash. DC

18. Funeral director Merritt Ronaldson
Address Laurel Md

19. Sept 22 1947 M. Brashears
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 21 1947 at 9:43 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1947 to September 21 1947
and that I last saw him alive on September 20 1947

	DURATION
Immediate cause of death: Pulmonary Edema	3 Days
Due to: Pulmonary Emphysema	1 year
Due to: Chronic Bronchitis	undetermined
Other conditions: Generalized arterio sclerosis	5 years

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE B P Warren M. D. or other
Address Laurel Md Date signed 9-22-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

47d

08179

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince George's
City or town: Riverdale (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mo. 14 days
Hospital, institution, or street address where death occurred: Leland Memorial Hospital
How long in hospital or institution? 1 mo. 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Prince George's
City or town: Laurel (If outside city or town limits, write RURAL and give nearest town)
Street No. 603 Main St (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Nellie Paul Barker
3. (b) Social Security Number: 132-22-0692

4. Sex: female
5. Color or race: white
6.(a) Single, married, widowed, or divorced: Divorced
6.(b) Name of husband or wife: Howard Clinton Barker
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Dec. 12, 1884

8. AGE: Years: 62 Months: 8 Days: 26 If less than one day ... hrs. ... min.

9. Birthplace: Pulaski County, Indiana (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Hibberd Paul
13. Birthplace: Dayton, Ohio

MOTHER
14. Maiden name: Evelyn Budd
15. Birthplace: Pulaski, Indiana

16. Informant: Mrs. John P. Barker (daughter in law)
Address: 603 Main St. Laurel Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 10 1947 (month) (day) (year)
Cemetery or crematory: Meadow Ridge Mem Park
Location: Wassey, Md.

18. Funeral director: W. Hill Donaldson
Address: Laurel, Md.

19. Sept 7 1947 (Date rec'd by registrar) James Severiz Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 7, 1947, at 12[17] P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/7, 1946, to Sept 7, 1947, and that I last saw her alive on Sept. 6, 1947

Immediate cause of death	DURATION
Carcinoma Lung.	1 yr
Carcinoma Cerebrum.	4
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: N. B. Steward M. D., or other
Address: Laurel Md. Date signed: Sept. 7, 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

08180

Reg. Dist. No. 230

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: I-C. Eastway
City or town: Greenbelt (If outside city or town limits, write RURAL and give nearest town) Maryland
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 10 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Prince Geo. Co.
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No.: 1-C - Eastway (If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: William Howard Blew

3. (b) Social Security Number:

4. Sex	5. Color or race	B.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Selma J
6.(c) If alive, give age: 58 years
7. Birth date of deceased (mo., day, yr.): Dec 13 - 1883

8. AGE: Years: 63 Months: 9 Days: 12 If less than one day: hrs. min.

9. Birthplace: Kane Pa (Town, county, and state)
10. Usual occupation: Chief
11. Industry or business: R-7-C. US Govt
FATHER 12. Name: Wm-C. Blew
13. Birthplace: Md
MOTHER 14. Maiden name: Mary Packer
15. Birthplace: Pa
16. Informant: Mrs Selma J Blew
Address: 1-C East way Greenbelt Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 29-'47 (month) (day) (year)
Cemetery or crematory: Forrest Lawn
Location: Kane Pa
18. Funeral director: The S.H. Hines Co.
Address: 2401 - 14th St NW
19. Sept - 25 1947 (Date rec'd by registrar) Mrs. Jas. Sevens Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 25, 1947 at 11-30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 25, 1947 to September 25 1947 and that I last saw him alive on September 25, 1947
Immediate cause of death: Subarachnoid hemorrhage — DURATION: 5 weeks
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operation: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?
23. SIGNATURE: Henry Wodak, M.D. M. D. or other
Address: 30-B Brid. Rd Greenbelt Md Date signed: 9/25/47

Mr. W. H Blew was attended by Dr Louis Ross, 1801 7th St. N.W. during his illness. Deceased Dr Ross. –

Dr Boyd, coroner, was notified & approved.

Thos Wadsworth M.D.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

132 08181

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: Glenn Dale, Md., - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 days
Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 45 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 103- C. St., S.E.
(If rural, give LOCATION)
2.(a) If veteran, name war: -

3.(a) FULL NAME: RICHMOND P. BOYDEN

3.(b) Social Security Number: 716-01-8714

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: -
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 11, 1899

8. AGE: Years 47 | Months 9 | Days 4 | If less than one day: hrs. min.

9. Birthplace: Statesville, N. Carolina (Town, county, and state)

10. Usual occupation: Engineer on railroad

11. Industry or business: -

FATHER
12. Name: John L. Boyden
13. Birthplace: unknown

MOTHER
14. Maiden name: Mary Davis
15. Birthplace: Statesville, N. Car.

16. Informant: deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 16/47 (month) (day) (year)
Cemetery or crematory: Rowan Co.
Location: Salisbury N. C.

18. Funeral director: W. W. Chambers Co.
Address: 1400 Chapin St. NW

19. Sept 15, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: SEPT. 15 1947 at 5:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from AUG. 1 1947 to SEPT. 15 1947 and that I last saw h.i. alive on SEPT. 15 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results: Pulmonary tuberculosis, tuberculous
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: David Leo Pinucane M.D. M. D. or other
Address: Glenn Dale, Md. Date signed: 9-15-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

08182

CERTIFICATE OF DEATH

Reg. Diat. No. 242

1. PLACE OF DEATH:

County: Prince Georges

City or town: Forestville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, Institution, or street address where death occurred: Brown Station Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Forestville
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Brown Station Road
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mammie Magdalene Broaden

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife: John H. Broaden

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 15, 1871

8. AGE:

Years	Months	Days	If less than one day
76	5	27	hrs. min.

9. Birthplace: Westphalia, Md.
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own Home

FATHER
12. Name: Henry Clegg
13. Birthplace: Maryland

MOTHER
14. Maiden name: Jane Clark
15. Birthplace: Maryland

16. Informant: George Clegg
Address: 524-1st St. N.W. Washington D.C.

17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year) 19

Cemetery or crematory: Forestville Md.

Location: Prince Georges County

18. Funeral director: Thos Frazier

Address: 389 N. Y. Ave

19. Sept 16 19 47 (Date rec'd by registrar) Edna F. Collins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 15 19 47 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
(a) Coronary Thrombosis	
Due to (b) Generalized Carcinomatosis	
Due to (c) Carcinoma of Colon	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Geo. T. Ford M. D. or other

Address: Forestville Md. Date signed 9-15-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

08183

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Pro Georges
City or town: Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pro Geo Co
City or town: Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3805 Oliver st
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: marietta Brooks

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: wm Brooks
6.(c) If alive, give age: —
7. Birth date of deceased (mo., day, yr.): sept 19, 1867

8. AGE: Years: 80 Months: Days: If less than one day: hrs. min.

9. Birthplace: mass (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business

FATHER
12. Name: addison Brooks
13. Birthplace: mass

MOTHER
14. Maiden name: martha morrison
15. Birthplace: new Hampshire

16. Informant: mrs mal Price
Address: Hyattsville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof sept 23. 1947 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: suitland Md

18. Funeral director: F Gaeche sons
Address: Hyattsville Md

19. Sept 23 1947 (Date rec'd by registrar) Mrs. Jas. Severe (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: SEPT. 20 1947 at 1.55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from AUGUST 29 1947 to SEPT. 20 1947 and that I last saw her alive on Sept. 19 1947

Immediate cause of death	DURATION
ACUTE CORONARY OCCLUSION	10 minutes
Due to: Benlized Arterio sclerosis	
Due to: HYPERTENSIVE CARDIOVAS. DISEASE	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: D. S. Clayman M.D. M. D. or other
Address: Mt. Rainier, Md Date signed: 9-20-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If no correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

08184

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

Reg. Dist. No. 232

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Pr. Geo

City or town: Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 hour

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Pr. Geo

City or town: Rural Cheltenham
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1 mi north
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Brown

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	

6.(b) Name of husband or wife: —

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): 15 Sept 47

8. AGE: Years | Months | Days | If less than one day: ____ hrs. 3 min.

9. Birthplace: Pr. Geo Co. Md.
(Town, county, and state)

10. Usual occupation: Work

11. Industry or business

FATHER
12. Name: Frank Brown
13. Birthplace: Clinton, Md

MOTHER
14. Maiden name: Frances Brown
15. Birthplace: Collington, Md

16. Informant: Nellie Bryan
Address: Cheltenham Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 17, 1947 (month) (day) (year)

Cemetery or crematory: Holy Rosary

Location: Rosaryville Md

18. Funeral director: John Brown

Address: Upper Marlboro Md Rt 1

19. Sept 17 1947 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 15 Sept 47 19 ____ at 11 43 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 Sept 1947 to 15 Sept 1947 and that I last saw h____ alive on ____ 19____

	DURATION
Immediate cause of death: Atelectasis	3 min
Due to: Premature birth	3 hrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: R B Isaacs MD
M. D. or other

Address: Upper Marlboro Date signed: 16 Sept 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08185

46e

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince Georges
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 days.
Hospital, institution, or street address where death occurred: Leland Memorial Hospital
How long in hospital or institution? 7 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince Georges
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Carters Lane
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Olga Woodruff Campbell

3.(b) Social Security Number: 500-03-9271

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 14. 1872

8. AGE: Years	Months	Days	If less than one day
75	4	14	hrs. min.

9. Birthplace: St. Louis Missouri (Town, county, and state)
10. Usual occupation: Practical Nurse
11. Industry or business

FATHER
12. Name: John Augustus Campbell
13. Birthplace: New York

MOTHER
14. Maiden name: Sophia Vasiloviena Pavloff
15. Birthplace: Alaska

16. Informant: Chart records
Address: Leland Memorial Hospital.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Sept. 30 1947 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery
Location: Suitland Maryland

18. Funeral director: Jas. Gawler's Sons
Address: 1756 Kenilworth Ave.

19. Sept. 28 1947 (Date rec'd by registrar) Mrs. Jas. Devers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 28 1947, at 4:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 21 1947 to Sept 28 1947 and that I last saw h[illegible] alive on Sept 28 1947

	DURATION
Immediate cause of death: Intestinal obstruction	1 week
Due to: Carcinoma of Sigmoid Colon	6 mo.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.:
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: L W Malin MD (M. D. or other)
Address: Riverdale, Md. Date signed: 9-28-47

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

08186

CERTIFICATE OF DEATH

Reg. Dist. No. 242

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Prince Geo.
City or town: Hillside Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 36 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Geo.
City or town: Hillside
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 836 59th Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3. (a) FULL NAME: JOHN EDWARD CATTS

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Jeanie M. Catts
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 25th 1869

8. AGE: Years	Months	Days	If less than one day
77	,	,	hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: Police
FATHER 12. Name: John L. Catts
13. Birthplace: Virginia
MOTHER 14. Maiden name: Lucy Dorcy
15. Birthplace: Virginia
16. Informant: Mr. William L. Catts
Address: 1304 57th Ave. N.E.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9-12-47 (month) (day) (year)
Cemetery or crematory: Mt Olivet
Location: Wash. D.C.
18. Funeral director: W.W. Chambers Co.
Address: 517 11th St. N.E.
19. Sept. 10 1947 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 9 1947 at 11:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 15 1947 to September 9 1947 and that I last saw h[illegible] alive on September 9 1947

	DURATION
Immediate cause of death: Respiratory failure	30 minutes.
Due to: Acute congestive heart failure	3 hours.
Due to: Coronary occlusion	4 days.
Other conditions: Parkinsons disease.	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Joseph J. McCarthy Jr. M. D. or other
Address: 6001 B St. S.E. Date signed: 9/10/47

Evidence for the change of age is shown on. S. 112 '9/10/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13/a

08187

CERTIFICATE OF DEATH

Reg. Diat. No. 242

1. PLACE OF DEATH:
County Prince George
City or town Chapel Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, Institution, or street address where death occurred: 8910 Old Fort Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George's
City or town Chapel Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8910 Old Fort Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Thomas Chew

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	married

6.(b) Name of husband or wife Maggie Chew
6.(c) If alive, give age 47 years
7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years	Months	Days	If less than one day
50			hrs. min.

9. Birthplace St Marys County, Md (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business Farm
FATHER 12. Name Thomas Chew
13. Birthplace Maryland
MOTHER 14. Maiden name Martha Douglas
15. Birthplace Maryland
16. Informant Agnes Stevens
Address #17 - 6th St NW Washington DC
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9 (month) 13 (day) 47 (year)
Cemetery or crematory Paynes Cemetery
Location #6 40 Benning Rd. NE
18. Funeral director John T. Rhines & Co
Address 904-3rd St. S.W.
19. Sept 16 1947 Edna F. Gelmis
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14 1947 at 2:00 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to Cardiovascular-renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Deputy medical Examiner M. D. or other
Address Hyattsville Md Date signed 9-14-47

VS-A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 122a

08188

CERTIFICATE OF DEATH

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Prince George
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? One month and 4 days
Hospital, institution, or street address where death occurred:
Prince George's General Hospital
How long in hospital or institution? One month and 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Laurel, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Laurel Sanitarium
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: CLAYTON A. CHRISMAN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 19, 1867

8. AGE: Years	Months	Days	If less than one day
80	8	0	hrs. min.

9. Birthplace: Berkeley County, W.Va.
(Town, county, and state)

10. Usual occupation: Retired minister

11. Industry or business:

FATHER
12. Name: George A. Chrisman
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Mary Eliza Linganafelter
15. Birthplace: W. Va.

16. Informant: Mr. W. A. Remer (Nephew)
Address: 4916-Hampden Lane, Bethesda 14, Md.

17. Burial, cremation, or removal. Which? Burial Date thereof: Sept 20 1947 (month) (day) (year)
Cemetery or crematory: Bethesda Md.
Location:

18. Funeral director: W. R. Pumphrey
Address: Bethesda Md.

19. 9/20 1947 (Date rec'd by registrar) Amanda Bourne Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 19, 1947, at 2:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1947 to Sept 19 1947 and that I last saw him alive on Sept 19 1947

Immediate cause of death	DURATION
Acute myocarditis	2 days
Due to: Bronchopneumonia	10 days
Due to: Strangulated inguinal hernia right side 122a	9 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert J. McKenney M.D. (M. D. or other)
Address: 402 Main St Laurel Md. Date signed: 9/20/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

111a 08189

Reg. Dist. No. 232

1. PLACE OF DEATH:
County: Prince George
City or town: Pitchers
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs. 5 mos.
Hospital, institution, or street address where death occurred:
Pr. Geo Co. Almshouse
How long in hospital or institution? 4 yrs 5 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pr. Geo
City or town: Bel Largo
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Charles Clapsticks

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 21, 1867

8. AGE: Years	Months	Days	If less than one day
80	6	3	hrs. min.

9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business
FATHER 12. Name: Fred Clapsticks
FATHER 13. Birthplace: Germany
MOTHER 14. Maiden name: Mary L
MOTHER 15. Birthplace: Germany
16. Informant: Pr. Geo Co. Almshouse
Address: 6501 Dorsey Rd SE. Washington, D.C.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 26, 1947 (month) (day) (year)
Cemetery or crematory: Pr. Geo. Co. Alms House
Location: Nitchers, Md.
18. Funeral director: Pitchers Bros
Address: Upper Marlboro, Md.
19. Sept 26 1947 (Date rec'd by registrar) R. Bird Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 24 1947 at 4 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2 1947 to Sept. 24 1947 and that I last saw him alive on Sept. 24 1947

Immediate cause of death	DURATION
Pulmonary Embolism	4 days
Due to Gangrene Right Foot-Leg	2 wks
Due to	
Other conditions Arteriosclerosis	10 yrs

(Include pregnancy within 3 months of death)
Major findings of operations: None
Date of op.
Autopsy results: No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE. If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: James E. Saucer M.D. or other
Address: Upper Marlboro - Md. Date signed: 9-24-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08190

Reg. Diat. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years, 21 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 2 years, 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1242 6½ St., N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: GERTRUDE CLEMENTS

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Separated

6.(b) Name of husband or wife: Arthur Clements

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 2, 1911

8. AGE: Years	Months	Days	If less than one day
36	1	18	hrs. min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Charwoman, War Department

11. Industry or business: —

FATHER
12. Name: Sam Hurt
13. Birthplace: ?

MOTHER
14. Maiden name: Amy ?
15. Birthplace: ?

16. Informant: Deceased

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof Sept 26/47 (month) (day) (year)

Cemetery or crematory: D. District Morgue

Location: Washington D.C.

18. Funeral director:

Address:

19. Sept. 20, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: SEPT. 20 1947, at 7:05 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from AUG. 29 1945 to SEPT. 20 1947 and that I last saw her alive on SEPT. 20 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 yr. 5 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel J. Finucane M.D. (M. D. or other)

Address: Glenn Dale, Md. Date signed 9-20-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 153

CERTIFICATE OF DEATH

08191

Reg. Diat. No. 232

1. PLACE OF DEATH:

County: Prince George

City or town: Mellwood.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: md County: Prince George

City or town: Mellwood

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Mrs Tessie Beall Coale

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John A. Coale

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): Aug. 19, 1897

8. AGE: Years: 49 | Months: | Days: | If less than one day: ...hrs. ...min.

9. Birthplace: Prince George Co. Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

MOTHER

12. Name: William T. Beall

13. Birthplace: Maryland

FATHER

14. Maiden name: Minnie Plunkett

15. Birthplace: Maryland

16. Informant: John A. Coale

Address: Upper Marlboro, Md. Rt #1

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 18, 1947 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Landover Md.

18. Funeral director: W. W. Chambers Co.

Address: 511-11th St. S.E. Wash. D.C.

19. Sept 15 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 15 Sept 1947, at 1.15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1947 to 15 Sept 1947 and that I last saw her alive on 15 Sept 1947

	OURATION
Immediate cause of death: Circulatory Collapse	6 hours
Due to: Lupus erythmatosus Disseminatus	10 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

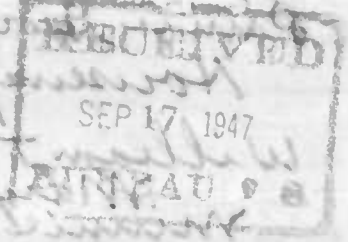
23. SIGNATURE: R. B. Lasseter M.D. M. D. or other

Address: Upper Marlboro, Md. Date signed: 15 Sept 47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING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08192

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1700

CERTIFICATE OF DEATH

Reg. Diat. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Prince Georges

City or town Cheverly (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months

Hospital, institution, or street address where death occurred: Prince Georges General Hospital

How long in hospital or institution? Dead on arrival

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Maryland Park (If outside city or town limits, write RURAL and give nearest town)

Street No. 407 - 65th Avenue (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Charles Edward Coates

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) February 25, 1935

8. AGE: Years 12 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Prince George's County, Md. (Town, county, and state)

10. Usual occupation Student

11. Industry or business

FATHER 12. Name Robert Hebb Coates

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden name Mabel F. Lambert

MOTHER 15. Birthplace District of Columbia

16. Informant Anna McGarry

Address 5885 Addison Rd, Seat Pleasant Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 30 1947 (month) (day) (year)

Cemetery or crematory Mt Olivet

Location Washington DC

18. Funeral director F. Gadelio Sousa

Address Bladensburg Md

19. Sept 28 1947 (Date rec'd by registrar) Amanda Lowrey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 1947, at 7:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage and Shock	
Due to Fracture of base of skull	
Due to Fracture and dislocation of second cervicle vertebrae	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 9-26-47

Where did injury occur? Seat Pleasant (City or town) P.G. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Central Ave

Means of injury Bicycle struck by car Injured at work? No

How injury occurred Deputy medical examiner

23. SIGNATURE [illegible] M. D. or other

Address [illegible] Date signed 9-26-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08193

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years, 24 days

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 6 years, 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington (If outside city or town limits, write RURAL and give nearest town)

Street No. 2443 - 18th St., N. W. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: George B. Colgan

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Separated

6.(b) Name of husband or wife: Victoria Colgan

6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): October 10, 1881

8. AGE: Years	Months	Days	If less than one day
65	11	0	..... hrs. ..... min.

9. Birthplace: Washington, D. C. (Town, County, and State)

10. Usual occupation: Piano tuner

11. Industry or business: -

FATHER — 12. Name: John Colgan; 13. Birthplace: Massachusetts

MOTHER — 14. Maiden name: Joanna Donovan; 15. Birthplace: Massachusetts

16. Informant: Deceased

Address:

17. (Burial, cremation, or removal. Which?) Removal Date thereof (month) (day) (year) Sept 10/47

Cemetery or crematory: to Washington DC

Location:

18. Funeral director: S. H. Hines Co.

Address: 2901 - 14th St. N.W.

19. (Date rec'd by registrar) Sept 10, 1947 Registrar: Rowland S. Phillips

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 10 1947 at 1 05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/26 1941 to Sept 10 1947 and that I last saw h... alive on Sept 10 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	8 yrs - 1 mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale, Md. Date signed 9/10/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47d

CERTIFICATE OF DEATH

Reg. Dist. No. 0819 239

1. PLACE OF DEATH
County: Prince George
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 weeks
Hospital, institution, or street address where death occurred: Warren Hospital
How long in hospital or institution? 4 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: P.G.
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No. 501 - 4th St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Katherine Miller Wale

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6.(b) Name of husband ~~or wife~~: Clarence L. Wale
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Nov 19, 1877

8. AGE: Years: 70 | Months: 6 | Days: 17 | If less than one day: ..... hrs. ..... min.

9. Birthplace: P.G. Co. Md.
(Town, county and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Charles L. Miller
13. Birthplace: Md

MOTHER
14. Maiden name: Ardella Rhodes
15. Birthplace: Wash. D.C.

16. Informant: Ardella Miller
Address: Laurel Md.

17. Burial, cremation, or removal. Which? Burial Date thereof: Sept. 8 1947
(month) (day) (year)

Cemetery or crematory: Lincoln Hills
Location: Laurel, Md.

18. Funeral director: Geo. Watts Donaldson
Address: Laurel Md.

19. Sept 8 1947 (Date rec'd by registrar) J. M. Brashears Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 5, 1947 19..... at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1947, to Sept 5 1947 and that I last saw h~~e~~r alive on Sept 3 1947

Immediate cause of death	DURATION
(a) Myocardial Failure	1 wk
Due to (b) Hypostatic pneumonia	3 days
Due to (c) Cerebrovascular thrombosis	1 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. M. Warren M.D.
M. D. or other

Address: Laurel Date signed: 9-5-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08195

131a

CERTIFICATE OF DEATH

Reg. Dist. No. 234

1. PLACE OF DEATH:
County: Prince George's
City or town: Allentown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1- Year
Hospital, Institution, or street address where death occurred: 7144 Allentown Rd S E.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pr. Geo. Co.
City or town: Allentown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 7144- Allentown Road. S. E.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Frederick G. Deems

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Florence G. Deems

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 7th. 1892

8. AGE: Years	Months	Days	If less than one day
55			hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Clerk, Wholesale Groceries
11. Industry or business: Mr. Gatti In Washington, D. C.

FATHER
12. Name: Charles L. Deems
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Magdoline Thomas
15. Birthplace: Baltimore, Maryland.

16. Informant: Mrs. Florence G. Deems
Address: 7144- Allentown Road. S.E.

17. Burial (Burial, cremation, or removal: Which?) Date thereof Oct 3- 47 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery
Location: Suitland, Maryland

18. Funeral director: Arthur E. Simmons
Address: 2017- Nichols ave S.E. Wash D C

19. Oct. 1 1947 Harold Beall
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 30th. 1947, at 6-P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Howard D. Ford Deputy medical Examiner M. D. or other
Address: Upper Marlboro Md. Date signed 9-30-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

08196

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 mos., 17 days

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 11 mos., 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington (If outside city or town limits, write RURAL and give nearest town)

Street No. 4509 - Edson Place, N. E. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: EDMONDS, LUCILLE

3. (b) Social Security Number:

4. Sex: Female

5. Color or race: Colored

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Rudolph Edmonds

6.(c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.): April 9, 1914

8. AGE:	Years	Months	Days	If less than one day
33	33	5	14	....hrs. ....min.

9. Birthplace: Newark, New Jersey (Town, county, and state)

10. Usual occupation: Printers Assistant

11. Industry or business: -

FATHER

12. Name: Robert Simms

13. Birthplace: Newark, New Jersey

MOTHER

14. Maiden name: Marie Garison

15. Birthplace: Washington, D. C.

16. Informant: Deceased

Address:

17. Removal (Burial, cremation, or removal, Which?) Date thereof 9. 26. 47 (month) (day) (year)

Cemetery or crematory: To Wash. D.C.

Location: Woodlawn Cemetery

18. Funeral director: Malvan & Schey

Address: 424 - R - St. N. W. (Per Burial)

19. Sept. 25 1947 Rowland S. Philips (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 25, 1947, at 11:30 p.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/7 1946, to 9/25 1947 and that I last saw her alive on 9/25 1947

Immediate cause of death	DURATION
pulm. tuberculosis	1 year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane MD (M. D. or other)

Address: Glenn Dale, Md. Date signed 9/25/47

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a 08197

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince George's
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 Mos
Hospital, institution, or street address where death occurred:
Chatham Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Chatham Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: George Wilson Fordray

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Elizabeth Fordray
6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): January 19, 1857

8. AGE: Years: 90 | Months: | Days: | If less than one day: ... hrs. ... min.

9. Birthplace: Kentucky (Town, county, and state)

10. Usual occupation: Retired Watchman

11. Industry or business: Railroad

FATHER
12. Name: Addison Monroe Fordray
13. Birthplace: Kentucky

MOTHER
14. Maiden name: Nancy Havenn
15. Birthplace: Kentucky

16. Informant: Felix Fordray
Address: Route #1, Box 114, Hyattsville

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 6. 1947 (month) (day) (year)
Cemetery or crematory: Ft Lincoln
Location: Washington D.C.

18. Funeral director: L Gaches sons
Address: Hyattsville Md

19. Sept 6 1947 (Date rec'd by registrar) James Seney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 4 1947, at 6.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to Cardio vascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of:
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of Injury: ... Injured at work?

Heart disease Epilepsy

23. SIGNATURE: James D. Ross M. D. or other
Address: Forestville Md Date signed: 9-4-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08198

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince Georges
City or town: Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Prince Georges General Hosp.
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Mt. Rainier.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4301 Russell ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: ROSA E. WILSON FRITZGERALD

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: Garrett Fritzgerald
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jun. 5, 1883

8. AGE: Years	Months	Days	If less than one day
64	8	21	hrs. min.

9. Birthplace: Delray W. Va.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Randolph Mowrey
13. Birthplace: Va

MOTHER
14. Maiden name: Malendie Howdyshell
15. Birthplace: W. Va.

16. Informant: Calvyle J. Wilson
Address: 4301 Russell ave. Mt. Rainier

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 30, 1947 (month) (day) (year)
Cemetery or crematory: Cedar Lane, Delray, W. Va.
Location: Delray, W. Virginia

18. Funeral director: W. W. Chambers Co.
Address: 1400 Chapin St. N.W. Washington, D.C.

19. 9/27 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 26 Sept 1947, at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18 Jan 1947 to 26 Sept 1947 and that I last saw her alive on 26 Sept 1947

	DURATION
Immediate cause of death: Cerebral Hemorrhage	6 days
Due to: Hypertensive Vascular Disease	2 years
Due to:	
Other conditions: Thyroid adenoma, nod. Toxic	10+ yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Samuel J. N. Seager M.D.
M. D. or other
Address: Mt. Rainier, Md. Date signed: 27 Sept 47.

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13 t S 08199

Reg. Diat. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos., 2 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 2 mos., 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1620 Rosedale St., N. E.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: EUNICE GAINOUS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife: -

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 9, 1931

8. AGE: Years	Months	Days	If less than one day
16 16	0	15	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Schoolgirl

11. Industry or business: -

FATHER 12. Name: Newitt Vanhook

13. Birthplace: ? Kentucky

MOTHER 14. Maiden name: Victoria Gainous (Williams)

15. Birthplace: Quincy, Florida

16. Informant: Victoria Gainous (Williams), Mother

Address: 1620 Rosedale St., N. E.

17. Burial, cremation, or removal. Which?: Removal Date thereof: 9/25/47. (month) (day) (year)

Cemetery or crematory:

Location: Washington D.C.

18. Funeral director: Joseph S. Gormley

Address: 2121 18 St. N.W.

19. (Date rec'd by registrar) Sept 24 1947 Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: SEPT. 24 1947 at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 21 1947 to Sept. 24 1947 and that I last saw her alive on Sept. 24 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	5 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 9/24/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1700

CERTIFICATE OF DEATH

08260

Reg. Diat. No. 32/5

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 months

Hospital, institution, or street address where death occurred:

Leland Memorial Hospital

How long in hospital or institution? 40 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Berwyn

(If outside city or town limits, write RURAL and give nearest town)

Street No. 9032 - 48th Place

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Malcolm George Garringer

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 15, 1924

8. AGE: Years 23 | Months 7 | Days 25 | If less than one day: hrs. min.

9. Birthplace: Kingston Pa

(Town, county, and state)

10. Usual occupation: Welder

11. Industry or business: Mechanic

FATHER 12. Name: George D. Garringer

13. Birthplace: Wilkinsburg Pa

MOTHER 14. Maiden name: Hazel V. Decker

15. Birthplace: Pennsylvania

16. Informant: George D. Garringer

Address: 9032 - 48th Berwyn

17. Burial, cremation, or removal. Which?: Burial Date thereof: Sept 10 47 (month) (day) (year)

Cemetery or crematory: Fort Lincoln Cemetery

Location: Washington D.C.

18. Funeral director: McClenahan & Co

Address: Riverdale, Md.

19. Sept. 8, 1947 (Date rec'd by registrar) Mrs. Jas. Devere (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 7 1947 at 12 03 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Intra Cranial Hemorrhage	
Due to: Fracture of skull	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op.: .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? Accident Date of 9-6-47

Where did injury occur? College Park P.G. Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Route #1

Manner of injury: Struck by Motor Vehicle While at work as Deputy Medical Examiner

23. SIGNATURE: [signature] M. D. or other

Address: [illegible] Date signed: 9-7-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The form at page is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08261

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: Glenn Dale, Md., - Rural (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs., 11 mo's, 15 days

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 5 yrs., 11 mo's, 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington (If outside city or town limits, write RURAL and give nearest town)

Street No. 5351- Hayes St., N.E. (If rural, give LOCATION)

2.(a) If veteran, name war –

3.(a) FULL NAME INEZ M. GIBSON.

3.(b) Social Security Number none

4. Sex: Female

5. Color or race: Colored

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife

6.(c) If alive, give age .... years

7. Birth date of deceased (mo., day, yr.) July 10, 1926

8. AGE:

Years	Months	Days	If less than one day
21	2	8	...... hrs. ...... min.

9. Birthplace: Washington, D. C. (Town, county, and state)

10. Usual occupation: none (school, time of admission)

11. Industry or business: –

FATHER

12. Name: Charles Gibson

13. Birthplace: ? Virginia

MOTHER

14. Maiden name: Estelle Gibson

15. Birthplace: ? Virginia

16. Informant: deceased

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Sept 18, 1947 (month) (day) (year)

Cemetery or crematory

Location: to Washington, D.C.

18. Funeral director: Henry S Washington & Sons

Address: 467 - N. St. N.W.

19. Sept 18, 1947 (Date rec'd by registrar) Rowland S. Philips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 18th 1947, at 6.05 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 3rd 1941, to Sept 18 1947 and that I last saw her alive on Sept 18th 1947

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	6 yr 3 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .... Date of op. ....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide .... Date of ....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury .... Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. (M. D. or other)

Address: Glenn Dale, Md. Date signed 9/18/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08202

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2322 - 14th Place, S. E.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: ROSE W. GREEN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife: - - -
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 7, 1934

8. AGE: Years	Months	Days	If less than one day
13 13	4	21	hrs. min.

9. Birthplace: St. Josephs, Missouri (Town, county, and state)
10. Usual occupation: Schoolgirl
11. Industry or business: -

FATHER
12. Name: Herbert H. Green
13. Birthplace: Shenandoah, Iowa

MOTHER
14. Maiden name: Florence Harrison
15. Birthplace: Luther, Oklahoma

16. Informant: Florence M. Green (Mother)
Address: 2322 - 14th Place, S. E.

17. Burial, cremation, or removal. Which?: Burial Date thereof: 9/29/47 (month) (day) (year)
Cemetery or crematory: Woodlawn Cem.
Location: Washington D. C.
18. Funeral director: Walter E. Hunter
Address: 2512 Sheridan Rd. S.E.

19. (Date rec'd by registrar) Sept. 28, 1947 Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 28, 1947, at 3.40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 22, 1947 to Sept. 28, 1947 and that I last saw h.. alive on Sept. 28, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	5 mo.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Pulmonary Tuberculosis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed: 9/28/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

08203 045
Reg. Diat. No.

1. PLACE OF DEATH:
County Prince George
City or town Riverdale, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 79 yrs.
Hospital, institution, or street address where death occurred:
Leland Memorial Hosp.
How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Riverdale
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6104 - Rhode Island Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME George Marion Hardy

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Daisy M. Hardy
6.(c) If alive, give age 70 years
7. Birth date of deceased (mo., day, yr.) Sept. 16, 1868

8. AGE: Years	Months	Days	If less than one day
79	0	4 days	hrs. min.

9. Birthplace maryland (Town, county, and state)
10. Usual occupation Retired P. O. Dept. clerk
11. Industry or business
FATHER 12. Name George Marion Hardy
13. Birthplace maryland
MOTHER 14. Maiden name ?
15. Birthplace ?
16. Informant Mrs. Ellen M. Hardy
Address 6104 R.I. Ave. Riverdale, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-24-47 (month) (day) (year)
Cemetery or crematory Wash. Nat'l Cemetery
Location Suitland Md
18. Funeral director H. H. Chambers Co
Address 5801 Cleveland Ave, Riverdale, Md
19. Sept. 23rd 1947 Mrs. Jas. Severd (Deputy) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22, 1947 at 1:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 14 1947 to Sept 22, 1947 and that I last saw h alive on Sept 22 1947
Immediate cause of death Congestive Heart Failure — DURATION 6 wks
Due to Arteriosclerotic Heart Dis. 10 yrs.
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operation Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE L W Malin M.D. M. D. or other
Address Riverdale Md Date signed 9-22-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

08204

CERTIFICATE OF DEATH

Reg. Dist. No. 242

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Prince Georges
City or town Parkland Dist.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Washington 19 DC
(If outside city or town limits, write RURAL and give nearest town)
Street No. 20 Maryland Ave, Parkland Md
(If rural, give LOCATION)
2.(a) If veteran, name war — no

3. (a) FULL NAME Charles Hartman

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Widowed

6.(b) Name of husband or wife Mary E. Hardesty
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 21 1857

8. AGE: Years 90 | Months — 1 | Days 23 | If less than one day ... hrs. ... min.

9. Birthplace Richmond, Va.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business Gardener

FATHER 12. Name Unknown

13. Birthplace Unknown

MOTHER 14. Maiden name Elizabeth (Unknown)

15. Birthplace Unknown

16. Informant Jessie Hartman
Address Washington 19 DC

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-14-47 (month) (day) (year)

Cemetery or crematory Fairhaven
Location Forestville Md

18. Funeral director Ritchie Brothers
Address Upper Marlboro Md

19. Sept. 15 1947 (Date rec'd by registrar) Edna F. Collins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14 1947 at 1.45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 14 1947 to Sept 14 1947 and that I last saw him alive on Sept 14 1947

	DURATION
Immediate cause of death Acute Coronary Thrombosis	9 Hours
Due to — General Arteriosclerosis	Unknown
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Natural Causes Date of injury
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Eric C. Van Tuyle M. D.
Address Washington 19 DC Date signed Sept 14 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08205

186a

CERTIFICATE OF DEATH

Reg. Dist. No. 231

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Prince Geo. Co.
City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 days
Hospital, Institution, or street address where death occurred:
Prince George Gen Hosp
How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Pr. Geo. C
City or town Riverdale
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5809 - Cleveland Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Hannah S. Herlocker

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	

6.(b) Name of husband or wife Orville F. Herlocker
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 6 1866

8. AGE: Years	Months	Days	If less than one day
81			hrs. min.

9. Birthplace Wellsburg Ind.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Asa Hayes
13. Birthplace Ind.

MOTHER
14. Maiden name Elizabeth Redick
15. Birthplace Ohio

16. Informant Husband Otto Herlocker
Address 5809 Cleveland Ave. Riverdale, Md

17. Buried (Burial, cremation, or removal. Which) Date thereof 9-20-47 (month) (day) (year)
Cemetery or crematory Ft. Lincoln Cemetery
Location Bladensburg Rd. D.C.

18. Funeral director W.W. Chandler Co
Address Riverdale, Md.

19. 9/20 1947 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 22 1947 at 3a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 2 1946 to Sept 20 1947
and that I last saw h alive on 9-19-47 19

Immediate cause of death	DURATION
Fracture Left Hip	2 weeks
Due to	
Due to	
Other conditions Generalized Advanced Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 8/30/47
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury Fall Injured at work?

23. SIGNATURE O. Deitz M.D.
M. D. or other
Address Hyattsville Md. Date signed 9-20-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

CERTIFICATE OF DEATH

C8206

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Brentwood

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Prince Georges

City or town: Brentwood Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4511 37th St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: NELLIE S. HUMPHRIES

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Frank M. Humphries

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 5, 1893

8. AGE: Years: 53 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Germantown, Maryland (Town, county and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Charles R. Hargett

13. Birthplace: Frederick, Maryland

MOTHER — 14. Maiden name: Clara Richter

15. Birthplace: Germantown, Maryland

16. Informant: Frank M. Humphries

Address: 4511-37th st., Brentwood, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/26/47 (month) (day) (year)

Cemetery or crematory: Glenwood Cemetery

Location: Wash. D.C.

18. Funeral director: W. W. Chambers Co.

Address: 5801 Cleveland Ave., Riverdale, Md.

19. Sept 25 1947 (Date rec'd by registrar) James Seery (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-23 1947, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-2 1943, to 9-23 1947

and that I last saw h[er] alive on 9-22 1947

Immediate cause of death	DURATION
Carcinoma of Left Breast & Metastasis to Both Lungs.	4 Yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of Left Breast. Date of op. 3-15-43

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: W. W. Chambers M.D. (M. D. or other)

Address: Mt. Rainier Md. Date signed 9-23-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The [illegible] age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08207

131a

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince George's

City or town: Jefferson Heights (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 1000 - 65th Place

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Prince George's

City or town: Jefferson Heights (If outside city or town limits, write RURAL and give nearest town)

Street No.: 1000 - 65th Place (If rural, give LOCATION)

2.(a) If veteran, name war: World War I.

3. (a) FULL NAME: Louis Allen Jones

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Colored	married

6.(b) Name of husband or wife: Edna May Jones

6.(c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.): Nov 13, 1880

8. AGE: Years: 66 Months: Days: If less than one day: hrs. min.

9. Birthplace: Murfreesboro Md (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Unemployed

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace: "

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: "

16. Informant: Edna May Jones

Address: 1000 - 65th St. Jefferson Heights, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 19 1947 (month) (day) (year)

Cemetery or crematory: Queens Chapel

Location: Murfreesboro Md.

18. Funeral director: Henry S. Washington & Son

Address: 467 N St. N.W

19. 9/16 19 47 Amanda Downey (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 16 19 47 at 1:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h alive on 19

Immediate cause of death: Acute pulmonary edema — DURATION

Due to: Acute Congestive Heart failure

Due to: Cardiovascular renal disease

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Deputy medical Examiner James L. Pyles M. D. or other

Address: Forestville Md Date signed: 9-16-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

56e

08208

CERTIFICATE OF DEATH

Reg. Dist. No. 242

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County PRINCE GEORGES

City or town HILLSIDE

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 MONTHS

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County PRINCE GEORGES

City or town HILLSIDE

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4907 OST SE

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

HALLIE PEEPLES KITCHENS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	DIVORCED

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 16, 1904

8. AGE: Years	Months	Days	If less than one day
43	5	13	hrs. min.

9. Birthplace WHITE SPRINGS, FLORIDA (Town, county, and state)

10. Usual occupation NURSE

11. Industry or business NURSE

FATHER

12. Name H. O. PEEPLES

13. Birthplace HAMILTON COUNTY, FLORIDA

MOTHER

14. Maiden name WESSIE E. GINN

15. Birthplace HEMINGWAY, S. CAROLINA

16. Informant Doris P. Cutts

Address 5002 OST HILLSIDE, MD

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-1-47 (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Suitland, Md.

18. Funeral director W. N. Chambers Co

Address 517-11 St. S.E.

19. Sept 30 1947 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPTEMBER 29 1947, at 4:57 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from JULY 2 1947, to SEPT 29 1947 and that I last saw h.E.R. alive on SEPTEMBER 23 1947

Immediate cause of death	DURATION
RETICULO BLASTOMA	6 years
Location: Mediastenum	
Due to 10/20/47 O.S.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ernest E Cornelius M.D.

M. D. or other

Address 4400 Bowlus Rd. SE Date signed Sept 29 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

(M) (I)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13G

08209

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County Prince Georges
City or town Glenn Dale, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 mos., 23 days
Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium
How long in hospital or institution? 7 mos., 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State D. C. County
City or town 4250 Lane Place, N. E., Washington (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME LAWSON, LYTELL M.
3. (b) Social Security Number 578-20-5468

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife —
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) September 4, 1922

8. AGE:	Years	Months	Days	If less than one day ... hrs. ... min.
24	24	11	28	

9. Birthplace Washington, D. C. (Town, county, and state)
10. Usual occupation Messenger
11. Industry or business Navy Department
FATHER 12. Name Randolph
13. Birthplace Washington, D. C.
MOTHER 14. Maiden name Cordelia Nickens
15. Birthplace Wakefield, Virginia
16. Informant Deceased
Address
17. Removal (Burial, cremation, or removal. Which?) Date thereof 9-1-47 (month) (day) (year)
Cemetery or crematory to Wash. DC
Location
18. Funeral director McGuire & Schey inc
Address 424 - R. St. N.W (Pen Bruce)
19. Sept 1, 1947 (Date rec'd by registrar) Rowland S. Philips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1, 1947, at 1:30 a. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/5 1947, to 9/1 1947
and that I last saw him alive on 9/1 1947

Immediate cause of death	DURATION
pulm. Tuberculosis	13 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE Daniel Leo Finucane M.D. M. D. or other
Address Glenn Dale, Md. Date signed 9/1/47

C8211

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Reg. Diat. No. 237

1. PLACE OF DEATH:
County: Pr. Geo Co.
City or town: Camp Springs
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 Mths
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pr. Geo Co
City or town: Camp Springs
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5550 Suit Rd S E
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Lillie May Littlefoord

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband ~~or wife~~: Norman Littlefoord
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 3 - 1880

8. AGE: Years	Months	Days	If less than one day
67	4	3	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own home

FATHER
12. Name:
13. Birthplace:

MOTHER
14. Maiden name: Mary Crawford
15. Birthplace: Maryland.

16. Informant: Mrs Charles Lassear
Address: 5550 Suit Road S E Wash 20 D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9/8/47 (month) (day) (year)
Cemetery or crematory: Parkland
Location: Forestville, Md.
18. Funeral director: Fletcher Bros
Address: Upper Marlboro, Md.

19. Filed Sept 8 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 6 19 47, at 3:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15 19 46 to Sept 6 19 47
and that I last saw h~~er~~ alive on Sept 6 19 47

Immediate cause of death	DURATION
Cerebral hemorrhage	3 days
Due to: arteriosclerotic hypertension	3 yrs
Due to:	
Other conditions: arteriosclerotic heart disease	3 yrs

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W Suit Fletcher M D (M. D. or other)
Address: 6906 Fletcher Rd S E Wash 19 D.C. Date signed: 9/6/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08211

1310

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George County
City or town: Colmar Manor, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Colmar Manor
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4200 Newton St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: AMANDA FLORENCE LONG

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Jonathan

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September 21, 1872

8. AGE:

Years	Months	Days	If less than one day
75			..... hrs. ..... min.

9. Birthplace: Williamsport, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Collins
13. Birthplace: Williamsport, Maryland

MOTHER
14. Maiden name: Elizabeth Elliott
15. Birthplace: Williamsport, Maryland

16. Informant: Mr. Frank W Long Son
Address: 4200 Newton St, Colmar Manor, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 1-47 (month) (day) (year)
Cemetery or crematory: Fort Lincoln Cemetery
Location: Wash. D.C.

18. Funeral director: W W Chambers Co.
Address: Riverdale md

19. 9/29 (Date rec'd by registrar) 19 47 Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 28 19 47 at 6:00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw him ..... alive on ..... 19.....

Immediate cause of death	DURATION
Intra Cranial hemorrhage	
Due to Carcinoma Enter renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Manner of injury ..... Injured at work? .....

23. SIGNATURE: James J. Boyd M. D. or other
Address: Forestville md Date signed 9-28-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1310

08212

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince Georges

City or town Hyattsville Heights

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, institution, or street address where death occurred:

102 Taylor Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Hyattsville Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No. 102 Taylor Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Albert Lawrence Lynn

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Colored	married

6.(b) Name of husband or wife Margaret Lynn

8.(c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) June 7, 1893

8. AGE: Years 54 Months Days If less than one day hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Servant

FATHER 12. Name Wesley Lynn

13. Birthplace Maryland

MOTHER 14. Maiden name Annie Gantt

15. Birthplace Maryland

16. Informant Mrs. Ann Lynn

Address 5010 Silver Hill Road, Suitland

17. Burial (Burial, cremation, or removal: Which?) Date thereof 9-27-1947 (month) (day) (year)

Cemetery or crematory Lincoln Cem.

Location Suitland Maryland

18. Funeral director Henry J. Washington & Son

Address 467 N St. N.W.

19. Sept. 24 1947 (Date rec'd by registrar) Carrie J. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23 1947, at 9:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury ..... Injured at work?

23. SIGNATURE James J. Ford M. D. or Coroner

Deputy medical examiner

Address Hyattsville Md. Date signed 9-23-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

C8213

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

Reg. Dist. No. 231

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County Pro Georges Co

City or town Cheverly Md. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 42 hours

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 42 hours

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Washington County King County

City or town Seattle, Washington (If outside city of town limits, write RURAL and give nearest town)

Street No. 463 Crockett Street (If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Mrs Nellie Lyon

3. (b) Social Security Number

4. Sex female

5. Color or race white

6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife Henry Lyon

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 12, 1865

8. AGE: Years 82 Months 2 Days 12 If less than one day ... hrs. ... min.

9. Birthplace Michigan (Town, county, and state)

10. Usual occupation housewife

11. Industry or business

FATHER 12. Name ----- Gilbert

13. Birthplace Michigan

MOTHER 14. Maiden name Ann Tayer

15. Birthplace unknown

16. Informant Henry C. Lyon

Address Hyattsville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 27, 1947 (month) (day) (year)

Cemetery or crematory Ft Lincoln

Location Washington D. C.

18. Funeral director Francis Gasch's Sons — Francis Gasch's sons

Address Hyattsville Md.

19. 9/26 19 47 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-24 1947, at 9:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1946, to Sept 24 1947, and that I last saw her alive on 9-24 1947

Immediate cause of death Cerebral accident — DURATION 3 days

Due to Hypertension Heart disease

Due to

Other conditions Generalized arteriosclerosis (Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [illegible] M. D. or other

Address Hyattsville Date signed 9/24/47

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 49a

08214

CERTIFICATE OF DEATH

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Prince George.

City or town Cheverly

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 days.

Hospital, Institution, or street address where death occurred:

Prince George General Hosp

How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George.

City or town Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4004 Jefferson St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Rosalie Lyon.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married.

6.(b) Name of husband or wife Henry Lyon.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 10-15- 1896

8. AGE: Years	Months	Days	If less than one day
50	10	29	..... hrs. ..... min.

9. Birthplace Ft. Snelling, Minn.

(Town, county, and state)

10. Usual occupation Housewife.

11. Industry or business

FATHER 12. Name Edgar R Ford.

13. Birthplace Virginia

MOTHER 14. Maiden name Helen McGinty

15. Birthplace Kansas

16. Informant Henry H. Lyon

Address 4004 Jefferson St. Hyattsville Md

17. Burial (Burial, cremation, or removal. Which?) Buried Date thereof 9-16-47 (month) (day) (year)

Cemetery or crematory Fort Lincoln Cemetery

Location Wash. D.C.

18. Funeral director W W Chaney Co

Address Riverdale Md

19. 9/14 1947 Amanda Devaney

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-13 1947 at 12:20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 1 1923 to Sept. 13 1947 and that I last saw h-er alive on 9-12 1947

Immediate cause of death	DURATION
Generalized Carcinomatosis of many organs in the Abdomen	
Due to Primary Carcinoma of Ovary.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE C. A. Doty M.D.

M. D. or other

Address Hyattsville, Md Date signed 9-13-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08215

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince Georges'
City or town: Glenn Dale - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 61 days
Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium
How long in hospital or institution? 61 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County: –
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1423- Howard St., N.W., Apt. #10
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: ANN MACHENBERG

3.(b) Social Security Number: 579-28-2817

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife: –
6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): April 7, 1904

8. AGE:

Years	Months	Days	If less than one day
43	5	9	... hrs. ... min.

9. Birthplace: New York City, N.Y. (Town, county, and state)
10. Usual occupation: Clerk in office.
11. Industry or business: –

FATHER
12. Name: Nathan Ellis
13. Birthplace: Stockholm, Sweden

MOTHER
14. Maiden name: Augusta M. Jenkins
15. Birthplace: ? , Finland

16. Informant: Deceased
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof Sept 15/47 (month) (day) (year)
Cemetery or crematory: to Washington D.C.
Location:

18. Funeral director: B Danzansky & Son
Address: 3501 - 14th St. N.W. Wash DC

19. Sept. 15, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: SEPT. 15 1947 at 1:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16 1947 to SEPT. 15 1947 and that I last saw her alive on SEPT. 15 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	9 mo.
Due to: Rheumatic Heart Disease	12 yr. 9 mo.
Due to: Diabetes Mellitus	1 yr. 3 mo.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: Pulmonary tuberculosis, mitral valvulitis and myocarditis
PHYSICIAN: Please underline the cause to which death should be charged ultimately.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ...
Means of injury: ... Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. (M. D. or other)
Address: Glenn Dale, Md. Date signed 9-15-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coroner is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

08216

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

56 b

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Mo. and 27 days
Hospital, institution, or street address where death occurred: Prince George's General Hospital
How long in hospital or institution? 1 Mo. and 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Hyattsville, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 3920 Livingston Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: LILLIAN MARKEY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Chas. Markey
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 25, 1904

8. AGE: Years	Months	Days	If less than one day
43	3	8	..... hrs. ..... min.

9. Birthplace: Cincinnati, Ohio (Town, county, and state)
10. Usual occupation: Gov. clerk
11. Industry or business

FATHER
12. Name: Max Berman
13. Birthplace: Europe

MOTHER
14. Maiden name: Ida Schusterman
15. Birthplace: Europe

18. Informant: Self
Address

17. Burial (Burial, cremation, or removal) Date thereof: Sept 6 1947 (month) (day) (year)
Cemetery or crematory: Ft. Lincoln
Location: Colmer Manor, Md.
18. Funeral director: J. C. Williams Lee & Son Co.
Address: 3010-4½ St N.E. DC

19. 9/4 1947 Amanda Dewey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 3, 1947, at 7:25 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Septicaemia	27 dys.
Due to: Purulent Peritonitis 129	27 dys
Due to: Post operative Hysterectomy	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Fibroid Uterus 8/29/47 as. 56 b Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Hyattsville, Md. Date signed 9-4-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 122a

08217

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County Prince George
City or town 309 Wash. Blvd. District Hgts, Md, Riverdale, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
4408 Queensbury Rd, Riverdale, Md.
How long in hospital or institution? 2 1/2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town District Hgts
(If outside city or town limits, write RURAL and give nearest town)
Street No. 309 Wash Blvd
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Marshall, Mrs. Irma Melva

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	wh	

6.(b) Name of husband or wife Marshall, Mr. Preston
6.(c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) Oct. 9 1909

8. AGE: Years	Months	Days	If less than one day
37			hrs. min.

9. Birthplace Wash. D.C. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name John Morris Hayes
13. Birthplace Maryland

MOTHER
14. Maiden name Emma Katherine Joy
15. Birthplace Wash. D.C.

16. Informant Husband
Address 309 Wash. Blvd., District Hts, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 24 47 (month) (day) (year)
Cemetery or crematory Cedar Hill
Location Suitland Md.

18. Funeral director W. W. Chambers
Address 517 Eleventh St. S.E. Wash D.C.

19. Sept 24 1947 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 Sept. 1947 at 1 00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12 1947 to Present-9-22 1947 and that I last saw her alive on 22 Sept. 1947

Immediate cause of death	DURATION
Peritonitis	2 days
Due to Surgery 8-12-47	10 days
Due to Tubal Ligation & Umbilical Hernia	
Other conditions Pregnancy Normal delivery Sept 7, 1947 (Include pregnancy within 3 months of death)	

Major findings of operation Re-Opened 9-21-47 Meconium generalized Peritonitis Date of op. 9-21-47
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Sidney W. Lowery M.D. M. D. or Other
Address 601 Wash. Blvd. Wash. 19, D.C. Date signed 9-22-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13b 08218

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: PRINCE GEORGES
City or town: GLENN DALE, MD
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year, 29 days
Hospital, Institution, or street address where death occurred:
GLENN DALE SANATORIUM
How long in hospital or institution? 1 year, 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: District of Col. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1625 N.J. ave NW
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: McBRIDE, COLETTE

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Separated

6.(b) Name of husband or wife: Joseph McBride
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 4, 1899

8. AGE: Years	Months	Days	If less than one day
48	8	7	hrs. min.

9. Birthplace: Warrenton, North Carolina (Town, county, and state)
10. Usual occupation: Char Woman, Dept. of Agri.
11. Industry or business: -

FATHER
12. Name: Cobbin Boyd
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Lucy Stallion
15. Birthplace: North Carolina

16. Informant: Deceased
Address:

17. (Burial, cremation, or removal. Which?) Removal Date thereof 9/12/47 (month) (day) (year)
Cemetery or crematory: to Washington, D.C.
Location:

18. Funeral director: Malcolm T. Seley
Address: 424 R St. N.W. Wash. DC

19. (Date rec'd by registrar) Sept 11, 1947 Rowland J. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 11, 1947, at 1.05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/13, 1946, to 9/11, 1947, and that I last saw h. alive on Sept 11, 1947.

Immediate cause of death	DURATION
Pulmonary Tuberculosis, Far advanced	1 yr 1 mo
Due to:	
Due to:	
Other conditions: Diabetes mellitus, Intermittent Laryngitis	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed: Sept 11, 1947

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08219

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince George

City or town: Beaver Heights (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, Institution, or street address where death occurred: 1505 Eastern Ave

How long in hospital or institution? N.K.N.E

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Prince George

City or town: Beaver Heights (If outside city or town limits, write RURAL and give nearest town)

Street No. 1505 Eastern Ave (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Austin N. Mc Millan

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Single

6.(b) Name of husband or wife: N.K.N.E.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 5, 1871

8. AGE: Years	Months	Days	If less than one day
76	5	23	— hrs. — min.

9. Birthplace: Robinson Co. N.C. (Town, county, and state)

10. Usual occupation: Retired, Trs. Salesman

11. Industry or business:

FATHER — 12. Name: Daniel H. Mc Millan

FATHER — 13. Birthplace: North Carolina

MOTHER — 14. Maiden name: Sarah M. Campbell

MOTHER — 15. Birthplace: North Carolina

16. Informant: Mrs. Annie Bridges

Address: 1505 Eastern Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 30 47 (month) (day) (year)

Cemetery or crematory: Ft. Lincoln Cem.

Location: Md.

18. Funeral director: W.W. Chambers Co.

Address: 517-11th St. S.E. Wash. D.C.

19. Sept 28 19 47 (Date rec'd by registrar) Amanda L. Browne Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 28 19 47 at 6:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 24 19 47, to Sept. 27 19 47 and that I last saw h[im] alive on Sept. 27 19 47

Immediate cause of death	DURATION
Lobar Pneumonia	
Due to: Generalized Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Philip A.E. Stebbins, M.D. (M. D. or other)

Address: 800 K.C. Ave S.E. Date signed: 9/28/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

B 08220

Reg. Dist. No. 245

1. PLACE OF DEATH

County: Prince George

City or town: Riverdale Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 days

Hospital, institution, or street address where death occurred: Leland Memorial Hospital

How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residences of mother)

State: Iowa County: ?

City or town: Davenport
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2720 - E - 18th St.
(If rural, give LOCATION)

2.(a) If veteran, name war: ~~war~~ ✓

3.(a) FULL NAME: Katherine Mary Michael

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: Hermann Peter Michael

6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): April 23, 1889

8. AGE: Years	Months	Days	If less than one day
58	4	17	....hrs. ....min.

9. Birthplace: Ireland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Patrick McCarthy

FATHER — 13. Birthplace: Ireland

MOTHER — 14. Maiden name:

MOTHER — 15. Birthplace: Ireland

16. Informant: Husband

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 9 1947 (month) (day) (year)

Cemetery or crematory: Cavalry Cemetery

Location: Davenport Iowa

18. Funeral director: H. C. Chambers Co.

Address: Riverdale. Md.

19. Sept. 9 19 47 (Date rec'd by registrar) Mrs. Jas. Severe Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 9, 1947 at 9:08 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 2, 1947 to Sept. 8 1947 and that I last saw h[illegible] alive on Sept. 8 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 wk.
Due to: Hypertension	
Due to: Nephritis, acute	1 wk.
Other conditions: Diabetes Mellitus	3 wks.

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?): —

Means of injury — Injured at work? —

23. SIGNATURE: Walcutt W. Gibson, M.D. M. D. or other

Address: Riverdale, Md. Date signed 9-9-47

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08221

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George
City or town: Mitchellville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Geo
City or town: Mitchellville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Crane Highway
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Arthur William Moreland c

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Josie Moreland
6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): 1892

8. AGE: Years: 54-2 | Months: 1 | Days: 1 | If less than one day: hrs. min.

9. Birthplace: Md (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:

FATHER
12. Name: John W Moreland
13. Birthplace: Md

MOTHER
14. Maiden name: Georgiana Richardson
15. Birthplace: Md

16. Informant: Jane Moreland
Address: Mitchellville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 8, 1947 (month) (day) (year)
Cemetery or crematory: Mt Carmel Cemetery
Location: Upper Marlboro Md
18. Funeral director: E Gascho sons
Address: Hyattsville Md

19: Sept 8 1947 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 4 1947 at 5:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 1947 to Sept 4 1947 and that I last saw him alive on Sept 3 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 yrs
Due to	
Due to	
Other conditions: Arteriosclerosis	10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: none Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE. If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James C. Tasker M.D.
M. D. or other
Address: Upper Marlboro Md Date signed: 9-4-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 0822242.

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect or key age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County Prince Georges

City or town Seabrook Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Seabrook,

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Thomas Winfield Morgan

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Laura Elizabeth Morgan 6.(c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) August 20, 1868

8. AGE: Years	Months	Days	If less than one day
79	1	6	hrs. min.

9. Birthplace Washington D.C. (Town, county, and state)

10. Usual occupation Carpenter (Millman)

11. Industry or business

FATHER 12. Name Geoege M. Morgan

13. Birthplace Washington D.C.

MOTHER 14. Maiden name Mary Virginia Mace

15. Birthplace Washington D.C.

16. Informant George Winfield Morgan (Son)

Address Seabrook, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 29 1947 (month) (day) (year)

Cemetery or crematory Cedar Hill Cem

Location Suitland Maryland

18. Funeral director F Gardis Sons

Address Hyattsville Md

19. Sept 27 1947 (Date rec'd by registrar) James Lewis Registrar

10-1-47. Mrs Jack Bennett

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-26 1947, at 9 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-4 1947, to 9-26 1947

and that I last saw him alive on 9-26-47 1947

Immediate cause of death	DURATION
Myocardial failure	2 wks
Due to Coronary sclerosis	6 Mo.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John P. Clem M.D. M. D. or other

Address Hyattsville Md Date signed 9-27-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 122a

08223 231

CERTIFICATE OF DEATH

Reg. Dist. No. ~~[illegible]~~

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Prince George

City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 Hours.

Hospital, institution, or street address where death occurred:
Prince George Gen. Hosp.

How long in hospital or institution? 17 hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Bladensburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 4911 Taylor Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mullinix, George E.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Emma Virginia Millinix

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 14th, 1862

8. AGE:

Years	Months	Days	If less than one day
85	7	24	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER
12. Name: Robert Mullinix
13. Birthplace: Maryland

MOTHER
14. Maiden name: Baker
15. Birthplace: - ?

16. Informant: Mrs. Elizabeth Poole
Address: 4911 Taylor Str. Bladensburg

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 10, 1947 (month) (day) (year)

Cemetery or crematory: Howard Chapel Cemetery

Location: Long Corner Maryland.

18. Funeral director: F. Gasch's Sons

Address: Hyattsville Maryland.

19. 9/9 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-8 1947, at 6 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 to 9-8 1947

and that I last saw him alive on 9-7 1947

	DURATION
Immediate cause of death: Coronary Thrombosis	Seldom
Due to: Op. for strangulated	
ventral hernia 10 days	
Due to: previous ill health	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: Jno. M. Hump M. D. or other

Address: Hyatts. Md Date signed: 9/8/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

130

08224

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince Georges
City or town: Fairmount Heights (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, institution, or street address where death occurred: 1021 - 58th Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: County:
City or town: Washington, D.C. (If outside city or town limits, write RURAL and give nearest town)
Street No. 471 Eye St. N.W. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Adam Armstrong Naylor

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Jan. 31, —?

8. AGE: Years 69 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Martinsburg, W.Va. (Town, county, and state)

10. Usual occupation: Nurse

11. Industry or business

FATHER
12. Name: George Naylor
13. Birthplace: Leesburg, Va.

MOTHER
14. Maiden name: Emily?
15. Birthplace: Martinsburg, W.Va.

16. Informant: Emma Naylor (Niece)
Address: 516 - 48th Pl. N.E. - D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 9-26-47 (month) (day) (year)

Cemetery or crematory:
Location: Washington, D.C.

18. Funeral director: Malwad & Sickey, Inc.
Address: 424 R. St. N.W.

19. Sept. 26 1947 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 26 1947, at 1:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 25 1947, to Sept. 26 1947, and that I last saw him alive on Sept. 25 1947

Immediate cause of death	DURATION
Uremia	
Acute Hemorrhagic Nephritis	
Heart Disease	
Due to: Malnutrition	
General Debility	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Thomas R. Linman, M.D. M. D. or other
Address: 101 Eastern Ave. N.E. Date signed: 9/26/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

08225

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: Glenn Dale - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 35 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2914- Sherman Ave., N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: James H. Neale

3.(b) Social Security Number: ?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	widowed

6.(b) Name of husband or wife: Mary Lilly
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Aug. 17, 1869

8. AGE:	Years	Months	Days	If less than one day
	78	0	1	____ hrs. ____ min.

9. Birthplace: Southriver, Maryland (Town, county, and state)
10. Usual occupation: Barber
11. Industry or business:

FATHER
12. Name: James H. Neale
13. Birthplace: ? Maryland

MOTHER
14. Maiden name: Ellen Boston
15. Birthplace: ? Maryland

16. Informant: Deceased
Address:

17. removal (Burial, cremation, or removal. Which?) Date thereof: Sept. 19, 1947 (month) (day) (year)
Cemetery or crematory: Harmony Cemetery
Location: Washington, D. C.
18. Funeral director: L. E. Murray & Son
Address: 1337-10th St., N.W., Washington, D. C.
19. Sept. 19 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 19 1947, at 9 12 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15 1947 to Sept 19 1947
and that I last saw him alive on Sept 19 - 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1 mo 12 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results: ____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed 9-19-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. (Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08226

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 mos., 17 days
Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 5 mos., 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1066-30th St., N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: HENRY O'CONNOR

3.(b) Social Security Number: 225-05-282

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Separated

6.(b) Name of husband or wife: Ada Worth O'Connor
6.(c) If alive, give age: 27 years

7. Birth date of deceased (mo., day, yr.): June 1, 1900

8. AGE: Years	Months	Days	If less than one day
47	3	6	...hrs. ...min.

9. Birthplace: Leonardtown, Maryland (Town, county, and state)
10. Usual occupation: Helper on truck
11. Industry or business: -

FATHER
12. Name: Robert O'Connor
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Lyles
15. Birthplace: Maryland

16. Informant: Deceased
Address

17. Burial, cremation, or removal. Which?: Removal — Date thereof: 9-8-1947 (month) (day) (year)
Cemetery or crematory: Washington D. C.
Location

18. Funeral director: Malvaney Schey
Address: 424 R St. N. W.

19. (Date received by registrar) Sept. 7, 1947 — Rowland S. Phillips, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: SEPTEMPER 7, 1947, at 1 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MARCH 20, 1947 to SEPT. 7, 1947 and that I last saw h. alive on SEPT. 7, 1947

Immediate cause of death	DURATION
PULMONARY TUBERCULOSIS	10 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: ... Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed: 9-7-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

CERTIFICATE OF DEATH

08227

Reg. Diat. No. 2245

1. PLACE OF DEATH:
County: Prince George's
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Transient
Hospital, institution, or street address where death occurred:
Buck Lodge Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Riggs Road R.F.D
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Leroy Francis Peter

3. (b) Social Security Number: 579-12-1142

4. Sex: male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Mildred Peter
6.(c) If alive, give age: 40 years
7. Birth date of deceased (mo., day, yr.): July 30, 1903
8. AGE: Years: 44 Months: Days: If less than one day: hrs. min.
9. Birthplace: Prince George's County, Md (Town, county, and state)
10. Usual occupation: Truck Driver
11. Industry or business: Hauling
FATHER 12. Name: William Oscar Peter
13. Birthplace: Maryland
MOTHER 14. Maiden name: Ida Irene Stone
15. Birthplace: Washington D.C.
16. Informant: Charles A Peter
Address: 9705 Dallas St, Silver Spring Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: SEPT-17-1947 (month) (day) (year)
Cemetery or ~~crematory~~: ROCK CREEK
Location: WASHINGTON, D.C.
18. Funeral director: Warren E Pumphrey
Address: SILVER SPRING MD.
19. Sept 17 1947 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 15 1947 at 11 55 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Coronary thrombosis	
Due to: Coronary sclerosis	
Due to: Cardiovascular renal disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.....
Autopsy results: as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: James E. Deputy Medical Examiner M. D. or other
Address: Forestville Md Date signed: 9-15-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159 08228

CERTIFICATE OF DEATH

Reg. Dist. No. 240

1. PLACE OF DEATH:
County Prince Georges
City or town Brandywine, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Prince Georges
City or town Brandywine Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME James Walter Pinkney

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col	Single

6.(b) Name of husband or wife none
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sep 18-1947

8. AGE: Years | Months | Days one | If less than one day 1 hrs. min.

9. Birthplace Brandywine Md
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER
12. Name Walter Pinkney
13. Birthplace

MOTHER
14. Maiden name Mamie Jenkins
15. Birthplace Bel Alton

16. Informant Amanda Jackson Midwife
Address Brandywine, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-19-47 (month) (day) (year)
Cemetery or crematory At Home on Farm
Location Brandywine Rural Md

18. Funeral director Walter Pinkney Acting
Address Cheltenham, Md

19. Sept 19 1947 (Date rec'd by registrar) F. D. Billingsley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sep 19 1947, at 6 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sep 18 1947 to Sep 19 1947 and that I last saw h.l.m. alive on Sep 18 1947

Immediate cause of death	DURATION
Premature birth 6 mo	25 hrs
Due to Premature birth	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John E Bowers M.D.
M. D. or other
Address Brandywine, Md Date signed 9/19/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

08229

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13/a

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince Georges

City or town: Cheverly, Maryland
(If outside city of town limits, write RURAL and give nearest town)

How long in above place of death? 10½ hours

Hospital, institution, or street address where death occurred:
Prince Georges General Hospital

How long in hospital or institution? 10½ hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Edmonston
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4902 49th Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Edwin G. Porter

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Margaret Porter

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 27, 1890

8. AGE: Years	Months	Days	If less than one day
57			..... hrs. ..... min.

9. Birthplace: San Malcos Texas
(Town, county, and state)

10. Usual occupation: Night watchman

11. Industry or business:

FATHER
12. Name: James R. Porter
13. Birthplace: Texas

MOTHER
14. Maiden name: Mary Barbee
15. Birthplace: Texas

16. Informant: Margaret E. Porter

Address: 4902 49th Ave. Edmonston, Maryland

17. ~~Sept~~ Burial (Burial, cremation, or removal. Which?) Date thereof Sept 9, 1947 (month) (day) (year)

Cemetery or crematory: Arlington Mat.

Location: Arlington, Va.

18. Funeral director: J.W. Chambers

Address: Riverdale, Md.

19. 9/6 1947 Miranda Deuney
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 5, 1947 at 6:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral thrombosis	
Due to: Cardio vascular renal disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Given above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

Deputy Medical Examiner

23. SIGNATURE: James J. Boyd M.D. or other

Address: Forestville, Maryland Date signed 9/6/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

134

S08230

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year, 2 mos., 30 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or Institution? 1 yr., 2 mos., 30 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1717 Seaton St., N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: RAGLAND EVELYN L.

3.(b) Social Security Number: 578-36-2733

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife: Percy Ragland

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 8, 1910

8. AGE:	Years	Months	Days	If less than one day
	37	0	28	hrs. min.

9. Birthplace: Philadelphia, Pennsylvania
(Town, county, and state)

10. Usual occupation: Maid - Hotel

11. Industry or business: -

FATHER — 12. Name: Clarence Frazier

13. Birthplace: Rockville, Maryland

MOTHER — 14. Maiden name: Ellie M. Stewart

15. Birthplace: Rockville, Maryland

16. Informant: Deceased

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 9/6/47 (month) (day) (year)

Cemetery or crematory

Location: Washington DC.

18. Funeral director: W Ernest Jarrod Co

Address: 1432 Pa Ave NW

19. Sept 5, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 5, 1947 at 9:35 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/5 1946 to 9/5 1947 and that I last saw her alive on 9/5 1947

Immediate cause of death	DURATION
pulm. tuberculosis	16 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane MD
M. D. or other

Address: Glenn Dale, Md. Date signed: 9/5/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

08231

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 234

1. PLACE OF DEATH:
County: Pr. George
City or town: accokeek
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pr. Geo
City or town: Accokeek Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: George Alec Rennoe

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Eva Pearl Rennoe
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 23, 1891

8. AGE:

Years	Months	Days	If less than one day
56	2	26	..... hrs. ..... min.

9. Birthplace: Pr. George Co. (Town, county, and state)
10. Usual occupation: Farming
11. Industry or business

FATHER
12. Name: Alec Rennoe
13. Birthplace: Pr. George Co.

MOTHER
14. Maiden name: Emma Taylor
15. Birthplace: Pr. George Co.

16. Informant: Eva Pearl Rennoe
Address: accokeek, md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/22/47 (month) (day) (year)
Cemetery or crematory: Shiloh M.E.
Location: Bryans Road, Md
18. Funeral director: Hurdle & Ryon
Address: Waldorf, Md.

19. 9/21/47 (Date rec'd by registrar) Mrs. Alton Davis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/19/47, at 12 15 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 19..47, to 9/19/47
and that I last saw h.. alive on 9/17/47

Immediate cause of death	DURATION
Myocardial insufficiency	
Due to: Pulmonary Tuberculosis	10 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury: ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Waldorf Md Date signed: 9/19/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08232

13 b

CERTIFICATE OF DEATH

Reg. Dist. No. 242

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: PRINCE GEORGE
City or town: MARYLAND PARK
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MD. County: PRINCE GEORGE
City or town: MD. PARK
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 6502-A ST. Md. Pk. Md
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: CHARLES K. RITTER
3.(b) Social Security Number:

4. Sex: M
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: GRACE M. RITTER
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): 12-12-1884

8. AGE:

Years	Months	Days	If less than one day
62	12		hrs. min.

9. Birthplace: Wash. D.C. (Town, county, and state)
10. Usual occupation: JEWELER
11. Industry or business:
FATHER
12. Name: ADAM RITTER
13. Birthplace: D.C.
MOTHER
14. Maiden name: BERTHA WEISE
15. Birthplace: D.C.
16. Informant: Grace M. Ritter
Address: 6502-A ST. Md Pk Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9 4 47 (month) (day) (year)
Cemetery or crematory: Wash. Natl.
Location:
18. Funeral director: W. N. Chambers Co
Address: 517-11 St S.E.
19. Sept 2 1947 (Date rec'd by registrar) Carrie F. Campbell, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 2 1947, at 9 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/9/37 19.., to Sept. 2 1947
and that I last saw him alive on Sept. 2, 1947 19..
Immediate cause of death: Pulmonary tbc — DURATION:
Due to
Due to
Other conditions: None
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: [illegible signature] M. D. or other
Address: 1252 ... Date signed: Sept 2 47

VS A15 9.45.15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

08233 231

Reg. Diat. No. ~~916~~ -

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Prince George

City or town: Cheverly

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 hours

Hospital, Institution, or street address where death occurred:

Prince George Gen. Hosp.

How long in hospital or Institution? 9 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Berwyn Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Branchville Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

Ann Scott

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Married

6.(b) Name of husband or wife: Jack Scott

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): November 8th 1922

8. AGE: Years	Months	Days	If less than one day
24			..... hrs. ..... min.

9. Birthplace: North Carolina (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Henry Jones

13. Birthplace: N.C.

MOTHER

14. Maiden name: Rag, Anna

15. Birthplace:

16. Informant: Jack Scott

Address: Berwyn Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 9 1947 (month) (day) (year)

Cemetery or crematory: Ivy Hill Cemetery

Location: Laurel Md.

18. Funeral director: F. Gasch's Sons

Address: Hyattsville Md.

19. 9/9 1947 (Date rec'd by Registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 6 1947 at PP M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-6 1947 to 9-6 1947 and that I last saw h... alive on 9-6 1947

Immediate cause of death	DURATION
Diabetic Coma	24 hours
Due to: Diabetes Mellitus	6 yrs.?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: [illegible] M.D. M. D. or other

Address: Mt. Rainier Md Date signed 9-7-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

08234

CERTIFICATE OF DEATH

Reg. Dist. No. 240

1. PLACE OF DEATH:
County: Prince Georges County
City or town: Address Waldorf, Md Rt 5
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? All his life
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Prince Georges
City or town: Waldorf. Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: John William Scott

3. (b) Social Security Number:

4. Sex	5. Color or race	8.(c) Single, married, widowed, or divorced
Male	Colored	married

6.(b) Name of husband or wife: Catherine Scott
6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): Aug 15th 1866

8. AGE: Years: 81 | Months: 0 | Days: 27 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Charles Co – Md
(Town, county, and state)

10. Usual occupation: Farming

11. Industry or business

FATHER
12. Name: Dont Know
13. Birthplace: —

MOTHER
14. Maiden name: Mary Butler
15. Birthplace: Charles Co – Md

16. Informant: Maud Lancaster
Address: Waldorf. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 15, 1947 (month) (day) (year)
Cemetery or crematory: St Mary
Location: Piscataway
18. Funeral director: Hunt & Pyoy
Address: Waldorf Md

19. Sept. 18 1947 (Date rec'd by registrar) F.H. Billingsley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 11 1947, at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1947, to Sept 11 1947
and that I last saw h, in alive on Sept 8 1947

	DURATION
Immediate cause of death: Chronic Myocarditis	one year
Due to: Arterio - Sclerosis & High Blood Pressure	indef.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John E Bowers, M D (M. D. or other)
Address: Brandywine, Md Date signed: 9/12/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08235

1316

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince Georges
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, Institution, or street address where death occurred: Prince Georges Hospital
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Caroline
City or town: Denton md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Short Mr Leland

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Married

6.(b) Name of husband or wife: Martha
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 12-19-1892

8. AGE: Years	Months	Days	If less than one day
54	8	12	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: Alpheus Short
13. Birthplace: Delaware

MOTHER
14. Maiden name: Dora Truitt
15. Birthplace: Maryland.

16. Informant: Wife Martha
Address: same

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 4, 1947 (month) (day) (year)
Cemetery or crematory: Denton
Location: Denton, Md
18. Funeral director: J. Virgil Moore & Son
Address: Denton Maryland
19. 9/3/1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1 September 1947 2 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 27 August 1947 to 1 Sept 1947 and that I last saw him alive on 1 Sept 1947

Immediate cause of death	DURATION
Chronic Nephritis & UREMIA	
Due to	
Due to Congestive Heart FAILURE; AURICULAR FIBRILLATION	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None — Date of op.
Autopsy results: No Autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —
Accident, suicide, or homicide: No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury Injured at work?

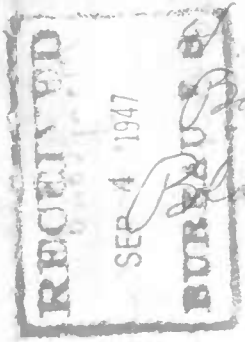
23. SIGNATURE: W. L. Etienne M. D.
Address: Berwyn, Md Date signed: 9-1-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Miss Downey
401
Balto. Ave.
Bladensburg, Md.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

CERTIFICATE OF DEATH

08236 245

Reg. Dist. No.

1. PLACE OF DEATH:
County: Prince George's County
City or town: Hyattsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 years
Hospital, Institution, or street address where death occurred: --
How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Hyattsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4007 Nicholson Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: ELSIE RUTH SIMPSON

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife: xxx Newton M. Simpson
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 25, 1897

8. AGE:	Years	Months	Days	If less than one day
	50			..... hrs. ..... min.

9. Birthplace: Loudon County, Virginia
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: John Bramhall
13. Birthplace: Loudon County, Virginia

MOTHER
14. Maiden name: Gretrude Baker
15. Birthplace: Loundon County, Virginia

16. Informant: Mr. Newton M. Simpson
Address: 4007 Nicholson Ave., Hyatts., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 22, 1947 (month) (day) (year)
Cemetery or crematory: Luthern Church Cemetery
Location: Lovettsville, Virginia.

18. Funeral director: W. W. CHAMBERS CO.
Address: 5801 Cleveland Ave., Riverdale, Md.

19. Sept 21 1947 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 21 1947 at 4 40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16 1947 to Sept. 21 1947 and that I last saw h.e. alive on Sept 20 1947

Immediate cause of death	DURATION
Carcinoma, multiple	
metastases	18 mos
Due to Carcinoma, right breast	2 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma, right breast — Date of op. Sept., 1945
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Julius Kaufman, M.D.
M. D. or other
Address: 5423 Arapahoe Rd. Date signed: 9/21/47
Bladensburg, Md.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08237

95c

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Prince George
City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mo 26 days
Hospital, institution, or street address where death occurred:
Laurel Sanitarium
How long in hospital or institution? 3 mo. 26 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2646 Kirk Ave. 318
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Blanche R. Smith

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife John W. Smith deceased
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) November 6 - 1864.

8. AGE: Years	Months	Days	If less than one day
82		28	hrs. min.

9. Birthplace Philadelphia Pa.
(Town, county, and state)
10. Usual occupation Home wife
11. Industry or business
FATHER 12. Name Chas Kingsmore.
13. Birthplace Pa.
MOTHER 14. Maiden name Rebecca Bond.
15. Birthplace Pa.
16. Informant Sanitarium Records.
Address Laurel Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/8/47 (month) (day) (year)
Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.
18. Funeral director WM. J. TICKNER & SONS
Address Balto., Md.
19. 9-6-1947 (Date rec'd by registrar) A. W. Hekrith Registrar
C.R.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4th 1947 at 4-40 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 13 1947, to Sept 4 1947
and that I last saw her alive on Sept. 4 1947
Immediate cause of death Acute Cardiac dilatation — DURATION 12 hr.
Due to Arteria Sclerosis -
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operation Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Clarence Hodson M.D.
M. D. or other
Address Laurel Sanitarium Date signed Sept 5 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

S 08238

Reg. Diat. No. 243

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 mos., 22 days
Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 5 mos., 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2622 K. St., N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Raymond E. Snowden

3.(b) Social Security Number: 578-16-5200

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 1, 1914

8. AGE: Years	Months	Days	If less than one day
32	9	2	hrs. min.

9. Birthplace: Washington, D. C. (Town, county, and state)
10. Usual occupation: Porter
11. Industry or business: —

FATHER
12. Name: Walter Snowden
13. Birthplace: Virginia

MOTHER
14. Maiden name: Mary Johnson
15. Birthplace: Maryland

16. Informant: Deceased
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof Sept. 3 1947 (month) (day) (year)
Cemetery or crematory:
Location: to Washington, D.C.

18. Funeral director: J. H. Bowie
Address: 2426 Ft. Pl. N.W.

19. Sept. 3, 1947 (Date rec'd by registrar) Rowland S. Phelps Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/3 1947 at 8 45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/11 1946 to 9/3 1947 and that I last saw h[illegible]alive on 9/3 1947

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 1 yr. 11 mos.
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed 9/3/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

08240

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince Georges
City or town: Bowie, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred: Bowie, Md
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Bowie
(If outside city or town limits, write RURAL and give nearest town)
Street No. — Bowie
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Stewart, Josephine

3.(b) Social Security Number

4. Sex: Fe
5. Color or race: Col
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Moses Stewart
6.(c) If alive, give age 48 years
7. Birth date of deceased (mo., day, yr.): May 30 1877

8. AGE: Years 70, Months 3, Days 9. If less than one day ....hrs. ....min.

9. Birthplace: Bowie, Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Unknown
13. Birthplace
MOTHER 14. Maiden name: Unknown
15. Birthplace
16. Informant: Neighbor - Mrs F. Clettams
Address: Bowie, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 11 47 (month) (day) (year)
Cemetery or crematory: Ascension Ch.
Location: Bowie Md
18. Funeral director: M. F. Clarkson Sons
Address: Bowie Md
19. Sept. 11 1947 Mrs. J. A. Yingling
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-8- 1947, at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1947, to July 1947 and that I last saw her alive on July 12 1947

	DURATION
Immediate cause of death: Cong. Heart Failure	3 mo.
Due to: Hypertensive Cardiovascular Disease	10 yrs
Due to:	
Other conditions: Pt had a cerebral hemmorage 6 mo ago. (Include pregnancy within 3 months of death)	

Major findings of operations —
Date of op.
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide .... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury .... Injured at work?

23. SIGNATURE John B. Lyons Jr MD
M. D. or other
Address: Bowie, Md. Date signed 9-10-47

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

08239

CERTIFICATE OF DEATH

Reg. Diat. No. 243

1. PLACE OF DEATH:
County Route # Defense Highway
City or town Bowie, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland Couoty Prince Georges
City or town Bowie,
(If outside city or town limits, write RURAL and give nearest town)
Street No. Route #1
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Clara B. Stough

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife Everett B. Stough
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) August 20, 1888

8. AGE:

Years	Months	Days	If less than one day
59			..... hrs. ..... min.

9. Birthplace Fayetteville Arkansas
(Town, county, and state)
10. Usual occupation housewife
11. Industry or business

FATHER
12. Name Laurence Seyler
13. Birthplace Unknown

MOTHER
14. Maiden name Unknown
15. Birthplace ?

16. Informant Everette B. Stough
Address Route #1 Bowie, Maryland
17. Burial Date thereof Sept 8, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Fort Lincoln Cemetery
Location 3201 - Bladensburg Rd. Colmar Manor
18. Funeral director William J. O'Malley
Address 3200 - R.I. Ave. Mt. Rainer, Md.
19. 9/7 1947 Amanda Downey Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4 1947 at 6 30/A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 22 1947 to Sept. 4 1947
and that I last saw h. Er. alive on Sept. 1 1947

Immediate cause of death	DURATION
Cerebro-vascular hemorrhage	
Due to Hypertensive cardiovascular renal disease	
Due to	
Other conditions Diabetes mellitus, diabetic arteritis, generalized neuralgia & sciatica	

(Include pregnancy within 3 months of death)
Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Julius Kaufman, M.D.
M. D. or other
Address 5423 Annapolis Road Bladensburg, Md. Date signed 9/4/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M


RECEIVED
SEP 13 1947

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

94a

08241

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince Georges
City or town: Riverdale, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 hours
Hospital, Institution, or street address where death occurred: Leland Memorial Hospital
How long in hospital or institution? 28 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3310 - Perry St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Edward Thompson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: ?
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 10, 1868

8. AGE:

Years	Months	Days	If less than one day
79	4	29	hrs. min.

9. Birthplace: Cincinnati, Ohio.
(Town, county, and state)
10. Usual occupation: Real Estate
11. Industry or business:

FATHER
12. Name: Edward J. Thompson
13. Birthplace: Cincinnati

MOTHER
14. Maiden name: Bridgett Kane
15. Birthplace: Cincinnati, Ohio.

16. Informant: Catherine Mc Mahon
Address: 3803-37th St. Mt. Rainier, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 11, 1947 (month) (day) (year)
Cemetery or crematory: Mt. Olivet Cemetery
Location: Mt. Olivet & Bladensburg Roads, N.E.

18. Funeral director: William J. Nalley
Address: 3200-R.I. Ave. Mt. Rainier, Md.

19 Sept 10 1947 (Date rec'd by registrar) Mrs. Jas. Severe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 8 1947 at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 7 1947 to Sept. 8 1947 and that I last saw h. l.m. alive on September 8 1947

Immediate cause of death	DURATION
Coronary Occlusion	5 hrs.
Due to	
Due to	
Other conditions: Generalized arteriosclerosis Nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: David A. Clagnaz, M.D. or other
Address: Mt. Rainier, Md. Date signed: 9-8-47

VS-A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08242

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year, 3 months, 3 days

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 1 year, 3 months, 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington (If outside city or town limits, write RURAL and give nearest town)

Street No. 609 New Jersey Avenue, N. W. (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: ESTATER WALLACE

3. (b) Social Security Number: 258-03-8040

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 23, 1910

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
36	11	19		

9. Birthplace: Savannah, Georgia (Town, county, and state)

10. Usual occupation: Laborer, Bureau of Engraving

11. Industry or business:

FATHER — 12. Name: Jackson Wallace

13. Birthplace: Savannah, Georgia

MOTHER — 14. Maiden name: Annie Brown

15. Birthplace: Savannah, Georgia

16. Informant: Deceased

Address:

17. removal - (Burial, cremation, or removal. Which?) Date thereof: Sept 14, 1947 (month) (day) (year)

Bureau Cemetery or crematory: South View Cem., Augusta, Ga.

Location: Annapolis, Md.

18. Funeral director: J. B. Johnson

Address: 34 Lafayette ave., Annapolis, Md.

19. Sept 11, 1947 (Date rec'd by registrar) Rowland S. Phelps Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 11, 1947 at 1.40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 7, 1947, to Sept. 11, 1947

and that I last saw him alive on Sept. 11, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1 yr 4 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glen Dale, Md. Date signed: 9/11/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08243

195e

CERTIFICATE OF DEATH

Reg. Diat. No. 231

1. PLACE OF DEATH:
County Pr. George
City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 days
Hospital, institution, or street address where death occurred:
P.G. Gen. Hosp.
How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Pr. Geo.
City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4505 Emerson St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Wannall, Mr. Walter

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	m

6.(b) Name of ~~husband~~ or wife Rebecca L. Wannall
6.(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.) apr. 22, 1888

8. AGE:

Years	Months	Days	If less than one day
59	4	20	____ hrs. ____ min.

9. Birthplace D.C. (Town, county, and state)
10. Usual occupation PBX Installer
11. Industry or business
FATHER 12. Name Wm. L. Wannall
13. Birthplace D.C.
MOTHER 14. Maiden name Mary Downey
15. Birthplace Md.
16. Informant Mrs. Rebecca Wannall
Address 4505 Emerson St. Hyattsville
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 13 1947 (month) (day) (year)
Cemetery or crematory Ft Lincoln
Location Colmar Manor, Md.
18. Funeral director J. Wm Lee Sons
Address 300-4th St NE
19. 9/11 19 47 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-11 1947 at 1:15 PM

21. I CERTIFY that death occurred on the date above etated; that I attended deceaeed from 9-3 1947 to 9-11 1947
and that I last saw h~~im~~ alive on 9-11 1947

	DURATION
Immediate cause of death (a) Peritonitis (129)	5 days
Due to (b) Disruption Wound, abdominal, post-operative (1356)	6 days
Due to (c)	
Diher conditions	

(Include pregnancy within 3 months of death) (126)

Major findings of operations (1) Colelithiasis (2) Resuture Wound (3) Resuture Wound Date of op (1) 9-5-47 (2) 9-6-47 (3) 9-8-47
Autopsy results none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. Willard Camalier Jr. M.D. M. D. or other
Address 1746-K St. N.W. Wash D.C. Date signed 9-12-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170c

08244

CERTIFICATE OF DEATH

Reg. Dist. No. 234

1. PLACE OF DEATH:
County: Prince Georges County
City or town: Clinton Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? -
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pro Geo
City or town: Hyattsville Maryland.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3934 Madison St.
(If rural, give LOCATION)
2.(a) If veteran, name war

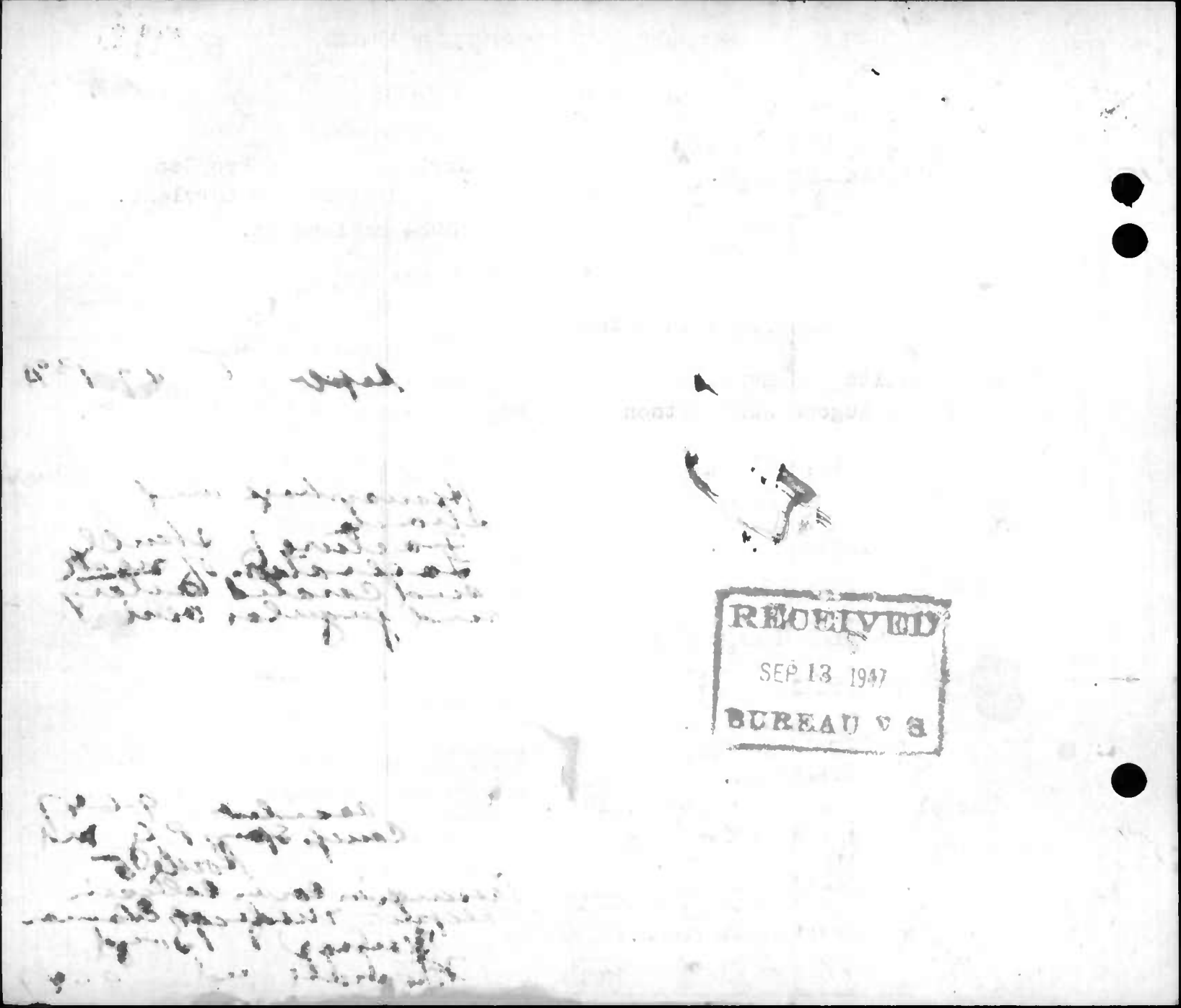
3. (a) FULL NAME: Minerva Ruth Watson
3. (b) Social Security Number

4. Sex: female
5. Color or race: white
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Eugene Reed Watson
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): May 13, 1918
8. AGE: Years 29 Months — Days — If less than one day ... hrs. ... min.
9. Birthplace: Washington D. C. (Town, county, and state)
10. Usual occupation: Houeswife
11. Industry or business
FATHER 12. Name: Charles Henry Hild
13. Birthplace: Maryland
MOTHER 14. Maiden name: Minnie Steinmire
15. Birthplace: Baltimore Md.
16. Informant: Geo. E. Hild
Address: Hyattsville Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 9, 1947. (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery
Location: Suitland Maryland.
18. Funeral director: F. Gasch's Sons — F. Gasch's sons
Address: Hyattsville Maryland.
19. 9/9 1947 (Date rec'd by registrar) Amanda Downey, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 6 1947 at 1:20 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...
Immediate cause of death: Hemorrhage and Shock
Due to: Fracture of skull
Due to: Laceration of neck and carotid artery and jugular vein
Other conditions
DURATION
(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 9-6-47
Where did injury occur? Camp Springs P.G. Md (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Route 5
Passenger in car in collision
Deputy Medical Examiner
23. SIGNATURE: [illegible] Boyd M. D. or other
Address: Hyattsville Md Date signed 9-6-47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SEP 13 1947
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08245

46 M

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince Georges
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Prince Georges Gen. Hospital
How long in hospital or institution? 50 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: California County: L
City or town: Long Beach
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4330 - Linden Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Mrs. Phoebe Wilson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	W. dowed

6.(b) Name of husband or wife: George Wilson
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Sept 8, 1865

8. AGE:

Years	Months	Days	If less than one day
82	0	18	..... hrs. ..... min.

9. Birthplace: Ohio (Town, county, and state)
10. Usual occupation:
11. Industry or business:
12. FATHER — Name: Stephen Bechtel
13. Birthplace: Pa.
14. MOTHER — Maiden name: Rosella Kelchner
15. Birthplace: ?
16. Informant: Daughter Mrs. Esther Wilson
Address: 3195 Perry St. Mt. Rainier
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-29-47 (month) (day) (year)
Cemetery or crematory: East Akron Cemetery
Location: Akron, Ohio.
18. Funeral director: Wm. J. Malley
Address: 3200 - R. Ave. Mt. Rainier, Md.
19. 9/27 19 47 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 26 Sept 19 47, at 10 45/a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Pernicious Anemia	2 yrs.
Due to: Generalized Arteriosclerosis	10 yrs
Due to: gastro - Intestinal Carcenomia	6 mos
Other conditions: Primary site unknown. 10/29/47 a.s	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Benjamin S. Mueller M. D. or other
Address: ..... Date signed .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

87c

08246

Reg. Diat. No. 245

1. PLACE OF DEATH:
County: Prince Geo. C
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: md County: Pr. Geo. Co.
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5911 - Harrison Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Julian C. Wright Sr

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	N	Married

6.(b) Name of husband or wife: Ida May Wright
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 30 - 1887

8. AGE: Years	Months	Days	If less than one day
69			..... hrs. ..... min.

9. Birthplace: Lynchburg Va
(Town, county, and state or foreign country)
10. Usual occupation: Printer (retired)
11. Industry or business: US Gov Printing Office

FATHER
12. Name: Julian Wright Sr
13. Birthplace: Washington D.C.

MOTHER
14. Maiden name: Unknown
15. Birthplace: "

16. Informant: Ida May Wright
Address: 5911 - Harrison Ave. Riverdale, md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 10 1947 (month) (day) (year)
Cemetery or crematory: Washington National
Location: Suitland Md. Prince George's County
18. Funeral director: W W Chambers Co.
Address: Riverdale. md.

19. Sept 9 " 19 47 Mrs. Jno. Severe Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 8 19 47 at 6 20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1939, to Sept 8 19 47 and that I last saw h alive on Sept 8 19 47

Immediate cause of death	DURATION
Malnutrition	4 Mo
Due to Parkinsons Syndrome	4 Yrs
Due to	
Other conditions General arteriosclerosis -	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: L W Malan M.D.
M. D. or other
Address: Riverdale Md Date signed 9-9-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct. Age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M